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ADP BULLETIN

Title	Issue Date: Aug 13, 2010 Expiration Date: N/A	Issue No.
DRUG MEDI-CAL CLAIMS PROCESSING REQUIREMENTS FOR BENEFICIARIES WITH OTHER HEALTH COVERAGE		10 - 09

Deputy Director Approval	Function:	Supersedes Bulletin/ADP Letter No. N/A
Marjorie McKeon for *dave neilsen* *Deputy Director* *Program Services Division*	[X]Information Management [ ]Quality Assurance [ ]Service Delivery [X]Fiscal [ ]Administration [ ]	

PURPOSE

This Bulletin provides additional clarification for counties and direct contract providers (referred to in this Bulletin as "trading partners") to submit Drug Medi-Cal (DMC) claims for beneficiaries who have other health coverage (OHC).

BACKGROUND

Under existing billing procedures, claims for certain beneficiaries with other health coverage (outside of Medi-Cal) require providers to first submit a claim for reimbursement to the other health coverage carrier, to receive adjudication results from that carrier, and to include information detailing the adjudication results when claiming DMC reimbursement for the services provided.

After considering input from trading partners, the Department of Alcohol and Drug Programs (ADP) is implementing changes to the existing procedures for these claims in order to permit a more efficient process for submitting claims and issuing reimbursement:

CLAIMS INSTRUCTIONS

1. Providers may presume that a claim for reimbursement submitted to an OHC carrier has been denied, and may submit a claim for DMC reimbursement on that basis, when all of the following are true:
   a. The provider has billed the service to the other carrier as required, and
   b. At least 90 calendar days have elapsed since the submission of the claim to the OHC carrier, and

c. The provider has received none of the following:
   i. Payment for the claim,
   ii. A report (whether in hardcopy, electronic, or other form) of the results of the OHC carrier's adjudication of the claims,
   iii. Any communication, in any form, indicating that the claim submission was in an unacceptable form or otherwise in need of correction prior to adjudication by the OHC carrier.

2. When billing for DMC reimbursement based on a presumed denial as described in #1, above, providers shall report the presumed denial as follows for up to 12 months:
   a. Enter adjustment group code "OA" ("Other Adjustments"),
   b. Enter adjustment reason code "192".

3. Providers may consider a claim for reimbursement for particular services denied by the OHC carrier without submitting a billing claim to the OHC carrier, and may submit a claim for DMC reimbursement on that basis, when all of the following are true:
   a. The provider has made an effort to bill the OHC carrier in the past 12 months,
   b. In response to the previous attempt to bill the carrier, the provider has received a dated notification in written or electronic form that clearly indicates that the OHC carrier does not at the time of notification, and will not for services provided in some specified span of time after the notification, accept claims for reimbursement from the provider, either in general or more specifically for particular types or circumstances of service,
   c. The services are within the scope of services for which the OHC carrier has indicated that they will not accept claims from the provider in the notification described in #3(b),
   d. The services were provided within the span of time identified in the notification described in #3(b) during which the OHC carrier would not accept the claims.

4. When billing for DMC reimbursement based on denial from a notification as described in #3, above, providers shall prepare their claims by mapping the justification for denial to the most appropriate combination of the standard code sets in force at the time the claim is created, or as submitted by the OHC carrier:
   a. Adjustment group code,
   b. Adjustment reason code, and,
   c. If necessary for the adjustment reason code given, health remarks code.

5. Trading partners shall retain all records relevant to the application of the rules communicated in this letter consistent with the records retention requirements identified in the State Administrative Manual and the trading partner's DMC or Net Negotiated Amount/DMC contract with the State.

REFERENCES

DMC Billing Manual

QUESTIONS/MAINTENANCE

For questions about processes and procedures involved in the submission of DMC claims, please contact your assigned Fiscal Management and Accountability Branch analyst. County and Direct Provider analyst assignment listings are available on ADP's DMC billing web page at http://www.adp.ca.gov/dmc_billing.shtml.

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